Lynn Van, *D.D.S.* ***Hang Van,*** *D.M.D.* ***Kim Van,*** *D.M.D.*
3185 Citrus Tower Blvd. Clermont, Fl. 34711
Office: (352) 241-8471
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Notice of Privacy Practices- Patient Acknowledgement

I have read and understand that this practice's Notice of Privacy Practices is written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I hereby authorize Bella Bella Dental Group Inc, to use and/or disclose the protected health information described above to_______________________________/__________________________
Name of Individual Relationship
I understand that this practice reserves the right to change the items of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

Print Patient's Name:_______________________Signature (Patient/Parent): ____________________________

Date:___________ Relationship to Patient : _____________________________

Cancellation And No Show Policy

In order to be fair to our loyal patients, who are waiting for sooner appointment times, any appointments that are broken or cancelled without the required 24-hour notice will incur a fee of $25.00 **per-half-hour** of scheduled time. **We understand that emergencies do sometimes occur**. We ask that you notify us as soon as possible, so they can be taken into consideration.

Print Patient's Name: ____________________________________ Signature (Patient/Parent):___________________

Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough evaluation and treatment recommendation. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistants as required to provide proper care. I agree to be present at time of any treatment for any of my dependent children under the age of 18 years old. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embody certain risks. I understand that I can ask for a complete recital of any possible risks. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.

Print Patient's Name: __________________________________Signature (Patient/Parent): _______________________

PLEASE TURN OVER

FINANCIAL AGREEMENT AND INSURANCE RELEASE

Please note the financial agreement applies to our insured & uninsured patients

Please understand that your insurance is a contract between you, your employer, and the insurance company. **WE ARE NOT PART OF THIS CONTRACT.** As a courtesy, our staff will bill your insurance company. However, if we do not hear from them within 45 days of the billing, the balance will become your responsibility and is to be paid in full. The responsibility will become yours to collect your reimbursement from your insurance company. "Usual and customary rate" means that an insurance company has a limit upon the amount it will pay on a procedure. Some insurance companies may pay on a much lower fee scale than others. The patient is responsible for any amount remaining after the insurance has paid its portion. We regret that we are unable to become involved in disputes between you and your insurance company regarding usual and customary rates, deductibles, or covered charges, other than to provide factual information.

I have read, acknowledged, and agree to the above policies. All information furnished by me is correct to the best of my knowledge. I authorize release of all pertinent information to my insurance company. I also authorize my insurance company to pay directly to Bella Bella Dental Group, the benefits to which I am otherwise entitled, if they have been assigned. I understand that when I undertake treatment in this office, I am responsible for all fees that incurred and agree to pay for services rendered, regardless of my insurance benefits. I understand that any information provided to me by this office regarding my insurance benefits is an "***ESTIMATE***" based on information received about my particular benefit contract, and **NOT a guarantee of payment**. I understand and agree to be responsible for payment of any balance remaining after Bella Bella Dental Group, receives expected insurance benefits. I understand a $25.00 fee will be assessed for all returned checks. This fee applies to all uninsured patients as well. I agree to be responsible for all attorneys' fees, court costs, and collection agency fees if my account is sent to an attorney for collection, or referred to a collection agency.

Print Patient's Name: ________________________________ Signature Patient/Parent: ___________________________

Witness (Staff member):___________________________